

CLINICAL RECORD REVIEW (CRR)

BLANK SFY23 QSR INSTRUMENT

ACCESS LOG (for DHHS BPQ USE ONLY)

Name	Date	PURPOSE

CLIENT NAME:

0	0
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SAMPLE CATEGORY:

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CMHC STAFF NAME:

0	0
---	---

STAFF POSITION:

0	
---	--

CMHC:

0	
---	--

PERIOD UNDER REVIEW:

7/1/2022	to	6/30/2023
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RECORD REVIEW COMPLETED BY:

DATE(S) OF REVIEW:

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OFFICE LOCATION:

Select From List

Has the individual been SMI/SPMI/LU eligible for the entire PUR?

0

If NO, what date did the individual become eligible?

01/00/00

CRR REVIEWER'S ADDITIONAL COMMENTS:

--

ASSESSMENT, TREATMENT PLANNING, AND SERVICES

CRR Q1 Was a case management assessment completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

--

	Assessed	Need Identified	List the Needs
Housing/Living Skills			
Employment			
Social/Family			

Name of Document:

--

Date of Document:

--

CLINICAL RECORD REVIEW (CRR)

CRR Q2 Was a case management plan completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

	Plan/Goal in this area	List the Plans/Goals/Explanations
Housing/Living Skills		
Employment		
Social/Family		

Name of Document:

Date of Document:

CRR Q3 Was an annual treatment plan/ISP completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

	Goal/Objective in this area	List the Goals/Objectives
Housing/Living Skills		
Employment		
Community Integration /Social Support		

Name of Document:

Date of Document:

CLINICAL RECORD REVIEW (CRR)

CRR Q4 Was the comprehensive assessment, Adult Needs and Strengths Assessment (ANSA), completed during the period under review? Yes, No Evidence, or CMHC Does Not Use ANSA? (Please record the most recent and complete the scoring section below along with any narrative comments found.)

	If CMHC DOES NOT USE ANSA or If NO EVIDENCE is selected, SKIP to CRR Q7				
Need	Score	Comments	Function/Strength	Score	Comments
Psychosis (Thought Disorder)			Physical/Medical		
Impulse Control			Family Relationships		
Mania			Employment/Educ.		
Depression			Social Functioning		
Anxiety			Recreational		
Interpersonal Problems			Living Skills		
Antisocial Behavior			Residential Stability		
Adjustment to Trauma			Living Situation		
Anger Control			Isolation		
Substance Use			Family/Family Strengths/Support		
Eating Disturbances			Interpersonal/Social Connectedness		
			Community Connection		
			Natural Supports		

Name of Document:

Date of Document:

CRR Q5 Were all the BEHAVIORAL/EMOTIONAL NEEDS, FUNCTIONING, AND RISK BEHAVIORS DOMAIN areas on the most current ANSA assessed and scored as 0, 1, 2, or 3? Yes or No?

If NO, as evidenced by (list the needs that were not assessed):

CLINICAL RECORD REVIEW (CRR)

CRR Q6 Were the STRENGTHS DOMAIN areas on the most current ANSA assessed and scored as 0, 1, 2, or 3? Yes or No?

If NO, as evidenced by (list the strengths that were not assessed):

CRR Q7 If an ANSA was not completed, was a similar current assessment of behavioral health needs and life functioning completed on a comparable document, i.e., the DLA-20? Yes or No Evidence?

As evidenced by:

Name of Document:

Date of Document:

CRR Q8 If an ANSA was not completed, was a similar ASSESSMENT OF STRENGTHS COMPLETED in a comparable document, i.e., DLA-20? Yes or No Evidence?

As evidenced by:

Name of Document:

Date of Document:

Please complete the below table with the most recent DLA-20 scores and comments:

Activities	Score	Comments	Activities	Score	Comments
Health Practices			Leisure		
Housing Stability & Maintenance			Community Resources		
Safety			Social Network		
Managing Time					
Managing Money					
Nutrition					
Problem Solving					
Communication			Behavior Norms		
Family Relationships					
Alcohol/Drug Use					

CLINICAL RECORD REVIEW (CRR)

CRR Q9 Please complete the following chart for all Behavioral/Emotional Needs in the ANSA or comparable assessment document. For the ANSA, ratings of 2 or 3 are considered a need and are autofilled below. For the DLA-20, ratings of 1, 2, or 3 are considered a need and must be manually entered. Refer to the scoring key in the assessment to determine how needs are identified if using another assessment.

[**REVIEWER**: If the CMHC used the DLA-20 or other comparable assessment rather than the ANSA, and MH needs were identified, manually change "NO" to "YES" in the "Needs Identified" column.]

Mental/ Behavioral Health Needs	Needs Identified YES/NO	Addressed in the ISP/CM PLAN? YES /NO	How so? What is the Goal/Objective/ Plan in the ISP or CM Plan?	Select Either TX Plan/CM Plan	TYPE [goal/obj/plan or barrier]
Psychosis (Thought Disorder)	NO	N/A	N/A	N/A	N/A
Impulse Control	NO	N/A	N/A	N/A	N/A
Mania	NO	N/A	N/A	N/A	N/A
Depression	NO	N/A	N/A	N/A	N/A
Anxiety	NO	N/A	N/A	N/A	N/A
Interpersonal Problems	NO	N/A	N/A	N/A	N/A
Antisocial Behavior	NO	N/A	N/A	N/A	N/A
Adjustment to Trauma	NO	N/A	N/A	N/A	N/A
Anger Control	NO	N/A	N/A	N/A	N/A
Substance Use	NO	N/A	N/A	N/A	N/A
Eating Disturbances	NO	N/A	N/A	N/A	N/A

In the box below, list **1)** the BH Need that was changed from a NO to a YES, **2)** the source that identified it as a need if using an assessment other than the ANSA, and **3)** the score and text that identified it as a need to support its inclusion above:

CLINICAL RECORD REVIEW (CRR)

CRR Q10 Please complete the following chart based on the individual's current treatment plan **goals** and their relation to an identified **need** in the **ANSA, Case Management Assessment**, or **comparable assessment document** (e.g. DLA-20):

GOALS IN THE CURRENT UNEXPIRED ISP	Assessed as an Identified NEED in the ANSA, DLA-20, CM Assessment, or Other Comparable Assessment? (YES/NO)	Identify 1) the Assessment Used (ANSA, DLA-20, CM Assessment, or specific other assessment used), 2) the Need Identified and 3) the Score or Narrative
Goal Count:	1	0
0.00%	:% of Goals in which a need has been identified during the assessment	
NO	%=100%	

CLINICAL RECORD REVIEW (CRR)

CRR Q11 Complete the tables based upon the individual's current annual ISP/ treatment plan and the frequency of services received **since the following date** (date of ISP):

01/00/00

TABLE A	ON ISP/ TX PLAN (YES/NO)	Frequency	Received (Y/ N/NA)	Received (Date)	Received at Prescribed Frequency (YES/NO/NA)	CPC	CPD
Individual Therapy						1/0/00	1/0/00
Case Management						1/0/00	1/0/00
Functional Support Services (FSS)						1/0/00	1/0/00
Group Therapy (DBT, etc.)						1/0/00	1/0/00
Prescriber Services						1/0/00	1/0/00
Supported Employment						1/0/00	1/0/00
Substance Use Disorder Treatment						1/0/00	1/0/00
Nursing Services (Assessments, etc.)						1/0/00	1/0/00
Other:							
						1/0/00	1/0/00
						1/0/00	1/0/00
						1/0/00	1/0/00

Totals:

0

0

%

#DIV/0!

0

% @ Freq

#DIV/0!

TABLE B Below, please explain **issues** with frequency, gaps in service provision, etc. **Include the name of the service, the frequency at which the service is prescribed, and the issue with frequency.** This information will assist the reviewer during the staff interview:

TABLE C (Only complete when it's PRN intent but not prescribed as PRN)

In the yellow-highlighted boxes, enter the actual PRN frequency prescribed.

		Indv Tx:	FSS:	Prescriber:	SUD:
#DIV/0!	:RECEIVED 70% or more of Services on TX Plan	Case Mgmt:	Group Tx:	SE:	Nursing:

CLINICAL RECORD REVIEW (CRR)

CRR Q12 Was the current ISP/treatment plan signed by the individual or verbally acknowledged by the individual? Yes or No Evidence?

Date of signature or verbal acknowledgement:

CRR Q13 Were the individual's strengths Included in the current ISP/treatment plan? Yes or No?

As evidenced by:

CRR Q14 Is the current ISP/treatment plan easy to understand (e.g., in the individual's words or written in a way that could be understood easily by anyone reading it)? Yes or No?

As evidenced by:

CRR Q15 Complete the chart entering all ISP reviews occurring during the PUR (most recent first, unless the most recent ISP review is not yet complete and the CMHC is still within their due date, then list the previously due ISP review first in the chart).

ISP Review dates (actual date range)	ISP Review Completed (Yes/No Evidence)	Summary of Progress (yes/no)	Individual Progress was Made (yes/no)	Indication of Change in Service Needed (Yes/No)	Treatment Plan AND/OR Service(s) Modified (Yes/No)	Explain Modifications that were needed and made/not made
		#DIV/0!	#DIV/0!	0	0	

#DIV/0! % of Progress Updates is 70% or Greater

#DIV/0! % of Progress Made is 70% or Greater

% of Modifications Made is 70% or Greater

CRR Q16 Were ISP reviews (the specific document) completed following each review period that has fallen all or in part within the PUR? Yes or No?

CLINICAL RECORD REVIEW (CRR)

HOUSING/LIVING SKILLS

HOUSING/LIVING SKILLS NEEDS/GOALS IDENTIFIER:

HOUSING/LIVING SKILLS NEED	NO
ISP GOAL	
CM PLAN	

If **ANY** of the identifiers to the left are **YES**, answer Q24. Otherwise, skip to **EMPLOYMENT SECTION**

CRR Q24 Was the individual assisted by the CMHC with his/her housing/living skills related needs and goals (related to residential stability as well as living skills/ADLs) in the past 12 months? Yes or No Evidence? [Reviewer: **Review needs & goals in Q26 below before answering this question.**]

If NO EVIDENCE, SKIP to Q26

Name of Document(s):

Date(s) of Document(s):

CRR Q25 Describe the type(s) of housing/living skills services and supports the individual received based on the document(s) listed in the previous question.

CRR Q26 Complete the reviewer codes below based on the information in the table.

Housing/Living Skills Needs:	
Housing/Living Skills Goals:	
Housing/Living Skills Services and Supports Received:	
0	
	REVIEWER CODE: GOALS ARE IN ALIGNMENT WITH NEEDS
	REVIEWER CODE: SERVICES & SUPPORTS ARE IN ALIGNMENT WITH NEEDS AND/OR GOALS

EMPLOYMENT

CRR Q27 Has the individual been enrolled in Supported Employment during the period under review? Yes or No?

As evidenced by:

Name of Document:

Date of Document:

CLINICAL RECORD REVIEW (CRR)

Was the individual's first day of enrollment in Supported Employment at least 30 days prior to the QSR start date? Yes or No?

	Enrolled prior to: 5/31/2023
--	------------------------------

Did the individual participate in Supported Employment for at least 30 days during the PUR? Yes or No?

--

CRR Q30 Were employment needs identified in either the ANSA, Case Management assessment, or other assessment? Yes or No?

	If the ANSA identifies an employment need despite a 0 or 1 entered, change Q30 to a YES, and then enter the need in the ANSA cell before skipping to EMPLOYMENT SERVICES/SE IDENTIFIER below. If nothing found, enter NO and skip to the Identifier.
--	--

CRR Q31 List those identified needs as identified on the ANSA, Case Management assessment, or other assessment.

CM Assessment:	
ANSA:	
DLA-20 or OTHER:	

EMPLOYMENT SERVICES/SE IDENTIFIER

SE SVS:	NO	If NO, skip to EMPLOYMENT NEEDS/GOALS IDENTIFIER above Q37.
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CRR Q35 Was an employment assessment (a.k.a. Vocational Profile or Vocational Assessment) completed? Yes or No Evidence?

	If NO EVIDENCE, Skip to Employment Needs/Goals Identifier above Q37.
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Name of Document:

--

Date of Document:

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CRR Q36 Complete the chart below based upon the employment assessment identified in Q35. The "As evidenced by" field must include evidence from the assessment that supports any "Yes" entered into the chart.

REVIEWER GUIDANCE: Use any narrative in the assessment to complete the chart.

Skills & Strengths Included? (Y/N)	Interests & Preferences Included? (Y/N)	Work History/Experience	Barriers to Employment Included? (Y/N)

As evidenced by:

--

CLINICAL RECORD REVIEW (CRR)

EMPLOYMENT NEEDS/GOALS IDENTIFIER

EMP NEED:	
ISP GOAL:	
CM GOAL:	

If ANY of the identifiers to the left are YES, answer Q37. Otherwise, Skip to COMMUNITY INTEGRATION AND SOCIAL SUPPORTS SECTION

CRR Q37 Was the individual assisted by **ANY MEMBER** of the treatment team with his/her employment related needs, goals or plans? Yes or No Evidence? [Reviewer: Review needs & goals in Q39 below before answering this question.]

If NO EVIDENCE, Skip to CRR Q39

Name of Document(s) [NOTE : Employment-related supports and services may be offered via SE, CM, FSS, Peer Support, Med, Prescriber, and/or Nursing services, and/or assessment and monitoring may be found in ISP Reviews]:

Date of Document(s):

CRR Q38 Describe the types of assistance or support provided to the individual related to his/her employment needs and goals based on the document(s) referenced in the previous question.

REVIEWER CODE: SERVICES WERE PROVIDED IN AN INTEGRATED COMMUNITY SETTING

CRR Q39 Please complete the reviewer codes below based on the information in the table:

Employment Needs:
Employment Goals:
Employment Services and Supports Received:
0

REVIEWER CODE: GOALS ARE IN ALIGNMENT WITH NEEDS

REVIEWER CODE: SERVICES ARE IN ALIGNMENT WITH NEEDS AND/OR GOALS

COMMUNITY INTEGRATION AND SOCIAL SUPPORTS

COMPLETE Q43

CRR Q43 Were social/community integration STRENGTHS and/or social/community integration NEEDS assessed anywhere else in the clinical record? Yes or No evidence?

CLINICAL RECORD REVIEW (CRR)

Only address the area that is blank. If YES is pre-filled in the 'Strengths Assessed' or 'Needs Assessed' cell, do not alter that cell. If one of the areas is blank, select an option in the drop-down menu for that cell after checking other assessments in the EHR to see if the identified area was assessed. Note: *Strengths or needs do not have to be identified, just assessed.*

Strengths Assessed

Needs Assessed

As evidenced by:

Name of document(s):

Date of document(s):

CRR Q44 Were needs related to those domains identified in either the case management assessment and/or the ANSA, and/or other assessment? Yes or No?

Check the assessment used in Qs 43 above to determine if social/community integration needs were identified. If a Need is identified, change the NO to a YES in Q44 and add the need to the "DLA-20 or OTHER" cell in Q45.

CRR Q45 Describe those identified needs.

CM Assessment:	
ANSA:	
DLA-20 or OTHER:	

COMMUNITY INTEGRATION IDENTIFIER

COMM NEED:	NO
ISP GOAL:	
CM GOAL:	

If ANY of the identifiers to the left are YES, answer Q48. Otherwise, Skip to CRISIS SECTION

CRR Q48 Was the individual assisted by the CMHC with his/her community integration and/or social support related needs and/or goals? Yes or No Evidence? [Reviewer: *Review needs & goals in Q50 below before answering this question .*]

If NO EVIDENCE, SKIP to Q50

CLINICAL RECORD REVIEW (CRR)

CRR Q49 Describe the types of assistance provided by the CMHC to the individual related to his/her community integration and/or social support needs and goals.

Name of Document(s):

Date of Document(s):

CRR Q50 Complete the reviewer code below based on the information in the table:

Community/Social Needs/Goals:	
Community/Social Services and Supports Received:	
0	
<input type="text"/>	REVIEWER CODE: SERVICES/SUPPORTS HAVE BEEN PROVIDED TO THE INDIVIDUAL TO ASSIST WITH HIS/HER IDENTIFIED NEEDS AND/OR GOALS

CRISIS

CRR Q51 Was a current crisis plan completed? Yes or No Evidence?

 If NO EVIDENCE, SKIP to CRISIS IDENTIFIER

Name of Document:

Date of Document:

CRR Q52 Was the current crisis plan written specifically for the individual and his/her situation (i.e., references his/her experiences, symptoms, people in his/her life as supports, interventions)? Yes or No?

As evidenced by:

CRISIS IDENTIFIER

1/0/00	CPC
1/0/00	CPD

If either of the identifiers display a date, but you do not find any evidence in the clinical record of crisis/emergency services being utilized, enter NO EVIDENCE for CRR Q53. If neither identifier displays a date, still check the locations within the clinical record indicated by the CRR crosswalk, and enter YES or NO for CRR Q53 accordingly.

CLINICAL RECORD REVIEW (CRR)

CRR Q53 Did the **individual** access or receive crisis/emergency (psychiatric) services **provided by the CMHC**? Yes, No, or No Evidence?

If NO or NO EVIDENCE, SKIP to ACT Section

CRR Q54 How many times did the **individual** access or receive crisis/emergency (psychiatric) services **provided by the CMHC**? **Count the note unless text in the documentation states the incident was NOT a crisis.**

As evidenced by:

CRR Q55 Complete the chart below for the **most recent** PSYCHIATRIC crisis/emergency service accessed by the **individual** and **provided by the CMHC**, and provide a narrative summary of the contact below the chart:
REVIEWER GUIDANCE: Use the most recent "crisis" note in the EMR **UNLESS** actual text in the the note states it was **NOT** a crisis. If text in the note states the incident was not a crisis, use the next most recent crisis note.

	Date		Type
	Risk Assessed?		Protective Factors Assessed?
	Plan was made?		Coping Skills Assessed?
	Staff Discussed Plan/Next Steps with Indv?		Indv Remained in Home/ Community Setting?

Summary of Crisis Contact: **REVIEWER GUIDANCE:** Narrative must include information that supports all the responses provided in the table above.

REVIEWER CODE: CRISIS SERVICE WAS PROVIDED BY ACT STAFF

REVIEWER CODE: CRISIS PROVIDED BY MOBILE CRISIS/RAPID RESPONSE TEAM (RRT)

Name of Document:

Date of Document:

ACT

ACT SCREENING IDENTIFIER

0 CPD

CRR Q56 Was an ACT screening completed? Yes or No Evidence?

Name of Document:

Date of Document

CLINICAL RECORD REVIEW (CRR)

CRR Q57 Has the individual been on ACT? Yes or No?

As evidenced by (include team name and date assigned):

CRR Q58 Is the individual currently on ACT? Yes or No? If YES, also complete the chart below regarding the past 4 weeks of ACT services:

If NO, SKIP to TRANSITIONS/DISCHARGE

Date range used to answer chart (see instructions*, **MONDAY THROUGH SUNDAY**):

10/24/2022 - 11/20/2022

	Week 1	Week 2	Week 3	Week 4	Total	Average
Date Range (Mon to Sun):	10/24/22-10/30/22	10/31/22-11/06/22	11/07/22-11/13/22	11/14/22-11/20/22		
How many distinct ACT staff did client have contact with? (CRR Q60)					0	0
How many minutes of service with ACT Staff? (CRR Q61)					0	0
How many total contacts with ACT Staff? (CRR Q62)					0	0
How many contacts with ACT Staff in which the client was in the home or community? (CRR Q63)					0	#DIV/0!

CRR Q59 How long have ACT services been provided to the individual?

CRR Q60 During the past 4 complete weeks (Mon-Sun), did the individual have contact with more than 1 different ACT Team staff each week, on average? Yes or No?

As evidenced by (if response is NO):

CRR Q61 During the past 4 complete weeks (Mon-Sun), did the individual have a minimum of 85 minutes of service with ACT Team staff each week, on average? Yes or No?

As evidenced by (if response is NO):

CRR Q62 During the past 4 complete weeks (Mon-Sun), did the individual have 3 or more total contacts with ACT Team staff per week, on average? Yes or No?

CLINICAL RECORD REVIEW (CRR)

As evidenced by (if response is NO):

CRR Q63 What is the percentage of ACT services received in which the individual was in the home or community in the past 4 complete weeks?

#DIV/0! :% of services provided in the community
 :THIS IS >= 60%

As evidenced by (if response is NO):

CRR Q64 Complete the following table:

ACT Team Roles	CMHC filled
Psychiatrist/APRN	
Psychiatric Nurse	
Employment Specialist	
Master's Level Clinician	
Subst. Abuse Specialist	
Team Leader	
Peer Specialist	

For CMHCs with multiple ACT teams, please indicate the name/location of the individual's ACT Team:

PSS First
Names:

TRANSITIONS/DISCHARGES

IPA ID (discharge dates)

1/0/00	CPC
1/0/00	CPD

If either of the identifiers displays a date, but you do not find any evidence in the clinical record, enter NO EVIDENCE for CRR Q65. If neither identifier displays a date, still check the locations within the clinical record indicated by the CRR crosswalk, and enter YES or NO for CRR Q65 accordingly.

CRR Q65 Has the individual experienced a transition/discharge from an inpatient psychiatric facility that **started** while the individual was enrolled at **this** CMHC? Yes, No, or No Evidence?

If NO or NO EVIDENCE, SKIP to COMPLETION TRACKING CHART

As evidenced by:

Date of Document:

CRR Q66 How many times was the individual discharged from an inpatient psychiatric facility during the PUR?

CLINICAL RECORD REVIEW (CRR)

CRR Q67 Please complete the following chart for any inpatient psychiatric admission and discharges the individual experienced during the PUR, **most recent first** :

Facility	DOA	DOD

	:# of readmissions w/in 90 days
	:INDIVIDUAL EXPERIENCED A READMISSION WITHIN 90 DAYS

For the following questions, please complete using the most recent inpatient psychiatric admission and discharge from:

CRR Q68 Does the clinical record include the discharge summary and/or discharge instructions from the inpatient facility? Yes or No evidence?

Name of Document:

Date of Document:

CRR Q69 Was there in-reach/communication with the inpatient facility or the individual during the individual's admission? Yes or No evidence?

If NO EVIDENCE, SKIP to Q72

CRR Q70 Describe the in-reach/communication:

Name of Document(s):

Date of Document(s):

CLINICAL RECORD REVIEW (CRR)

CRR Q72 Describe the type(s) of service(s) and summarize the focus of the first day of CMHC appointment(s) following transition/discharge and include the date of appointment where indicated:

First Appointment

Date:

Name of Document:

Date of Document:

REVIEWER GUIDANCE: In this next section, select the type of service provided on the first appointment date entered above. Select as many services as apply on the date of the first appointment.

TYPE OF SERVICE(S) PROVIDED ON FIRST APPOINTMENT DATE

<div></div>	Case Management	<div></div>	SE/IPS
<div></div>	FSS	<div></div>	Peer Support
<div></div>	Therapy	<div></div>	Other
<div></div>	Medical/Med Mgmt		

REVIEWER GUIDANCE: In this next section, select the all topics that were discussed on the first appointment date. Select as many topics as apply.

TOPICS DISCUSSED

<div></div>	Recent Admission	<div></div>	Risk Assessment
<div></div>	Support System	<div></div>	Medication Mgt
<div></div>	Symptom Mgt	<div></div>	Disruptions
		<div></div>	Other

CRR Q73 Did the individual start or continue ACT following transition/discharge, within 30 days? Yes or No?

As evidenced by:

CRR Q74 Was the individual involved in his/her discharge planning process? Yes or No Evidence?

As Evidenced by:

Name of Document(s):

Date(s) of Document(s):

CLINICAL RECORD REVIEW (CRR)

Completion Tracking Chart

CRR Complete (initial/and including self check):	NO
Notified CRR Team Lead to Submit No Evidence Form:	NO
CRR No Evidence Form Reviewed:	NO
CRR QA Check Complete:	0
CRR QA Follow-Up Complete:	NO